CASEREVIEW

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IRO CASE #: XXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Medial Branch Block Injection Bilateral C4-5, C5-6, C6-7

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is a Board Certified Anesthesiologist with over 8 years of experience, including Pain Management

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)
Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who was injured on XXXX while working as a XX in a XX. He was pinned between a XX and a XX. Previous treatment has included cervical ESIs with good pain relief, electroceutical stimulation, physical therapy, injections and medication.

On XXXX, the claimant underwent a CX ESI TL.

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On XXXX, MRI of the Cervical Spine, Impression: 1. Disc space narrowing with diffuse annular bulge at C3/4 along with a small superimposed right posterolateral disc protrusion. Moderate right C4 foraminal stenosis. 2. Mild annular bulge at C5/6 with small superimposed central disc protrusion. 3. Prominent disc space narrowing at C6/7 with ridge of posterior osteophytes and diffuse annular bulge. Bulge and osteophytes are slightly more prominent toward the left posterolaterally.

On XXXX, the claimant presented for cervical spine pain radiating to the right upper extremity. He described his pain level as 10/10 and wanting medication refills. On examination he had decreased strength and tone due to head and neck pain. He was unable to produce full resistance with head and neck. There were muscle spasms at the trapezius. There was tenderness and stiffness at the right paravertebral from C6 through C7. Diagnosis: Sprain of ligaments of cervical spine. Hydrocodone-acetaminophen 10-325 was prescribed and Norco was refilled. Referral to XX office.

On XXXX, the claimant presented. He had not seen XX yet as he needed an updated MRI in order to be seen. Medications were refilled and MRI ordered.

On XXXX, MRI Cervical Spine, Impression: 1. Borderline central spinal canal stenosis at C6-C7.2. Multilevel foraminal stenosis which is most prominent at C6-C7 bilaterally and at C3-C4 on the right side. 3. 2 cm thyroid nodule/cyst.

On XXXX, the claimant presented with continued neck pain with radiation, rated 10/10. It was noted XX was recommending ACDF. Would like to request bilateral C4-7 MBB prior to undergoing surgery. He had facet tenderness on exam and pain with flexion and extension. Could be a candidate for RFA based on findings. XX indicated there was tenderness upon palpation of the area as well as exacerbation of the pain upon hyperextension and rotation of the cervical spine. For the upper cervical facets only, there was also reproduction of the patient's headaches upon compression of the upper cervical facets along with hyperextension of the cervical spine.

On XXXX, UR. Rationale for Denial: ODG Guidelines, Neck Chapter states while not recommended, criteria for use of therapeutic intra-articular and medial branch b locks, if used anyway there should be evidence of a formal plan of rehabilitation in addition to facet joint injection therapy. The patient returned for a 2-month follow-up for cervical spine pain radiating to the right upper extremity and medication refills. The pain level was 8/10. Treatment plan included chronic opioid therapy. The patient was to return to the clinic in 1 month. The patient was diagnosed with sprain and/or strain of the neck. Documentation does not substantiate failure of conservative treatment (including home exercise, physical therapy and NSAIDS) prior to the procedure for at least 4 to 6 weeks. Medical necessity of the requested medial branch block injection bilateral C4-5, C5-6, C6-7 is not medically necessary.

On XXXX, UR. Rationale for Denial: The patient has bulges and facet changes on his MRI. A cervical fusion has been suggested. The patient has noted cervical spasm, tenderness, reduced range of motion, and a normal neuro exam. There is no indication the injection is to be done in conjunction with post injection rehab as per ODG criteria. Therefore, the request is not medically necessary.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous adverse determinations are upheld. The patient returned for a XX follow-up for cervical spine pain radiating to the right upper extremity and medication refills. The pain level was 8/10. There was noted cervical spasm, tenderness, and reduced ROM. Treatment plan included chronic opioid therapy. A cervical fusion has been suggested. Per ODG, while not recommended, criteria for use of therapeutic intra-articular and medial branch blocks, if used, should include evidence of a formal plan of rehabilitation in addition to facet joint injection therapy. There is no documentation that the injection will be done in conjunction with post injection rehab. Therefore, medical necessity of the requested medial branch block injection bilateral C4-5, C5-6, C6-7 is not established.

PER ODG:

Facet joint diagnostic blocks	Recommended prior to facet neurotomy (a procedure that is considered "under study"). Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBB. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 27% to 63%) but

this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself.

Technique: The described technique of blocking the medial branch nerves in the C3-C7 region (C3-4, C4-5, C5-6, and C6-7) is to block the named medial branch nerves (two injections). Authors have described blocking C2-3 by blocking the 3rd occipital nerve. Another technique of blocking C2-3 is to block at three injection points (vertically over the joint line, immediately above the inferior articular facet at C2 and immediately below the superior articular facet at C3). (Barnsley, 1993) The medial branch nerve innervates the facet joint, facet capsular ligaments, the interspinous and supraspinous ligaments, spinous processes and paraspinal muscles. Relief of pain could be due to blockade of nociceptive input from any combination of these. It is suggested that the volume of injectate for diagnostic medial branch blocks be kept to a minimum (a trace amount of contrast with no more than 0.5 cc of injectate) as increased volume may anesthetize these other potential areas of pain generation and confound the ability of the block to accurately diagnose facet pathology. A recent study has recommended that the volume be limited to 0.25 cc.

Epidemiology of involved levels: Using cadaver evidence facet arthrosis most commonly affects the upper cervical levels, and increased with age, and was very rare in patients less than 40 years of age. C4-5 is the most common level followed by C3-4 and C2-3. This study did not attempt to identify number of levels of involvement.
(Lee, 2009)
Number of levels of involvement: In a randomized controlled trial of therapeutic cervical medial branch blocks it was stated that 48% of patients had 2 joints involved and 52% had three joints involved. (Manchikanti, 2008) These levels were identified by the pain pattern, local or paramedian tenderness over the area of the facet joint, and reproduction of pain to deep pressure. (Manchikanti, 2004) Other prevalence studies from this group also indicated that the majority of patients with cervical involvement were treated at three joints. Target joints were identified as noted above. (Manchikanti, 2004). There are no studies that have actually tested levels of involvement using individual injections for diagnostic verification.
(Lord, 1996) (Washington, 2005) (Manchikanti , 2003) (Dreyfuss, 2003) (Falco, 2009) (Nordin, 2009) (Cohen, 2010) See the Low Back Chapter for further references.

Complications: See Facet joint therapeutic steroid injections.

Criteria for the use of diagnostic blocks for facet nerve pain:
Clinical presentation should be consistent with facet joint pain, signs & symptoms.
1. One set of diagnostic medial branch blocks is required with a response of ≥ 70%. The pain response should be approximately 2 hours for Lidocaine.
2. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally.
3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.
4. No more than 2 joint levels are injected in one session (see above for medial branch block levels).
5. Recommended volume of no more than 0.5 cc of injectate is given to each joint, with recent literature suggesting a volume of 0.25 cc to improve diagnostic accuracy.
6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.
7. Opioids should not be given as a “sedative” during the procedure.
8. The use of IV sedation may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.
9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing

	the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. 12. It is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**